

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1.
 - a. Whether there should be additional reimbursement for date of service 8-27-01.
 - b. The request was received on 8-22-02.

II. EXHIBITS

1. Requestor, Exhibit I:
 - a. TWCC 60 and Letter requesting Medical Dispute Resolution
 - b. UB-92
 - c. EOB
 - d. Medical Records
 - e. Healthcare Network participation and service agreement dated 7-30-92
 - f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent, Exhibit II:
 - a. TWCC 60
 - b. Letter Responding to Request for Medical Dispute Resolution
 - c. Methodology
 - d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 9-20-02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 9-20-02. The response from the insurance carrier was received in the Division on 10-2-02. Based on 133.307 (i) the insurance carrier's response is timely.
4. Notice of A letter Requesting Additional Information is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 9-16-02:

“(Provider) charges the above-referenced services at a fair and reasonable rate. Specifically, these rates are based upon a comparison of charges to other Carriers and the amount of reimbursement received for these same or similar services. The amount of reimbursement deemed to be fair and reasonable by (Provider) is at a minimum of 70%

of billed charges. This is supported by a managed care contract with (healthcare plan) that is attached as Exhibit 1. This managed care contract supports (Provider's) argument that the usual and customary charges are fair and reasonable and at the very least, 70% of the usual and customary charges is fair and reasonable. This managed care contract exhibits that (Provider) is requesting reimbursement that is designed to ensure the quality of medical care and to achieve effective medical cost control as the managed care contract shows numerous Insurance Carrier's willingness to provide 70% reimbursement for Ambulatory Surgical Centers medical services".

2. Respondent: Letter dated 10-3-02.
"This dispute involved the carrier's payment for date of service 8/27/01. The requester billed \$12427.68; (Carrier) paid a total of \$517.00. The requester believes it is entitled to an additional of \$4914.68. 1. There is no MAR for outpatient ASC services.... 7. (Carrier's) payment is consistent with the fair and reasonable criteria established in Section 413.011 (b) of the Texas Labor Code....In this dispute (Carrier) took the service (myelogram) used by the surgeon, and applied its methodology to determine its fair and reasonable payment of \$517.00."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 8-27-01.
2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer.
3. Per the Requestor's Table of Disputed Services, the Requestor billed the Carrier \$12,427.68 for services rendered on the date of service in dispute above.
4. Per the Requestor's Table of Disputed Services, the Carrier paid the Requestor \$517.00 for services rendered on the date of service in dispute above.
5. The Carrier's EOBs/audit sheets denied any additional reimbursement as "M – OPSR – FAIR AND REASONABLE REIMBURSEMENT FOR THIS ENTIRE BILL IS MADE ON THE 'OR SERVICE' LINE ITEM; M – THE REIMBURSEMENT FOR THE SERVICE RENDERED HAS BEEN DETERMINED TO BE FAIR AND REASONABLE BASED ON BILLING AND PAYMENT RESEARCH AND IS IN ACCORDANCE WITH LABOR CODE 413.011 (B)".
6. The amount in dispute is \$4,914.68 for services rendered on the date of service in dispute above, per the Table of Disputed Services.

V. RATIONALE

Medical Review Division's rationale:

The medical documentation indicates the services were performed at an ambulatory surgery center. Commission Rule 134.401 (a)(4) states ASCs, “shall be reimbursed at a fair and reasonable rate....”

Section 413.011 (d) of the Texas Labor Code states, “Guidelines for medical services must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fees charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual’s behalf. The Commission shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines.”

Per Rule 133.304 (i), “When the insurance carrier pays a health care provider for treatment(s) and/or service(s) for which the Commission has not established a maximum allowable reimbursement, the insurance carrier shall:

1. develop and consistently apply a methodology to determine fair and reasonable reimbursement amounts to ensure that similar procedures provided in similar circumstances receive similar reimbursement;
2. explain and document the method it used to calculate the rate of pay, and apply this method consistently;
3. reference its method in the claim file; and
4. explain and document in the claim file any deviation for an individual medical bill from its usual method in determining the rate of reimbursement.”

The response from the carrier shall include, per Rule 133.307 (j) (1) (F), “.... if the dispute involves health care for which the Commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the amount the respondent paid is a fair and reasonable rate of reimbursement in accordance with Texas Labor Code 413.011 and §133.1 and 134.1 of this title;”.

The carrier, according to their position statement, asserts that they have paid a fair and reasonable reimbursement. The carrier indicates in their methodology that two national resources are utilized in determining a fair and reasonable reimbursement, “....ASC charges as listed by CPT code in ‘1994 ASC Medicare Payment Rate Survey’ and ASC Group payment rates as determined by the Secretary of the U.S. Department of Health and Human Services for surgical procedures by CPT code....(Carrier) used this data in the following manner; 1) The payment rate for the service in dispute, as defined by the CPT code, is determined using Medicare’s ASC Group rates. 2) The median charge from ASCs, weighted by total volume, is determined for the service group. 3) The co-payment amount is determined by multiplying the median weighted facility charge by 20%. 4) The dollar amounts from B.1) and B.3) above are summed to determine the fair and reasonable payment for the service.” The carrier then took the service (myelogram) used by the surgeon and applied the above methodology to arrive at \$517.00.

Due to the fact that there is no current fee guideline for ASC's, the Medical Review Division has to determine, based on the parties' submission of information, which has provided the more persuasive evidence of what is fair and reasonable. As the requestor, the health care provider must supply documentation that "...discusses, demonstrates, and justifies that the payment being sought is a fair and reasonable rate of reimbursement..." pursuant to TWCC Rule 133.307 (3) (g) (D). The Provider has submitted a copy of a managed care contract indicating payment of 70% was expected. However, that contract is 10 years old. It does not provide current information. The Provider has not provided sufficient information that supports its fees billed are fair and reasonable.

The law or rules are not specific in the amount of evidence that has to be submitted for a determination of fair and reasonable. The Medical Review Division has reviewed the file to determine which party has provided the most persuasive evidence. In this case, the Requestor has failed to support their position that the amount billed is fair and reasonable. Respondent has submitted a methodology that supports their position that the amount paid represents a fair and reasonable reimbursement. Therefore, no additional reimbursement is recommended.

REFERENCES: The Texas Workers' Compensation Act & Rules: Sec 413.011 (d); Rule 133.304 (i); Rule 133.307 (g) (3) (D) and (j) (1) (F).

The above Findings and Decision are hereby issued this 23rd day of April 2003.

Lesa Lenart
Medical Dispute Resolution Officer
Medical Review Division

LL/ll